IMPORTANT INFORMATION

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To All Providers:

- Bulletin, *BT200207,* dated February 15, 2002, contained information about 2002 Health Care Procedure Coding System (HCPCS) code updates. The effective date for the new 2002 HCPCS codes originally listed as April 1, 2002, has changed to be retroactive to January 1, 2002. The HCPCS codes deleted for 2002 will be end-dated effective December 31, 2001. EDS will not reprocess claims previously denied for edit *4032 – Procedure not on file*. Providers can resubmit denied claims, or submit an adjustment request for a paid claim, if the old code paid a different rate from the new 2002 code. Direct questions about the date change to EDS Customer Assistance at (317) 655-3240 in the Indianapolis area or 1-800-577-1278 outside the Indianapolis area.
- Bulletin, *BT200207,* dated February 15, 2002, incorrectly listed HCPCS codes to be used for Norplant. Table 1 lists the correct codes:

Table 1 – Correct Codes for Norplant

Deleted Code	Replacement Code	Description
X3000	11975	Insertion, implantable contraceptive capsules
X3001	11976	Removal, implantable contraceptive capsules
X3002	11977	Removal with reinsertion, implantable contraceptive capsules
X3003	11977	Removal with reinsertion, implantable contraceptive capsules

In accordance with *CPT Changes, An Insider's View 2002,* published by the American Medical Association, "Codes 11981–11983 differ from the other implant codes 11975–11977, in that codes 11975–11977 are also a type of non-biodegradable capsule, but are specific for contraceptive use." New 2002 Current Procedure Terminology (CPT) codes, 11981–11983, and the description for clarification, are listed in Table 2:

Table 2 – New 2002 CPT Codes

New 2002 CPT Code	Description
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with insertion, non-biodegradable drug delivery implant

Additionally, in Bulletin *BT200207,* HCPCS local codes used to bill prenatal care coordination services for initial assessments, reassessments, and postpartum assessment/outcome will change. *BT200207, page 50, Table 1.4 – Deleted HCPCS Codes*, lists the deletion of local codes used to bill prenatal care coordination services and their replacement national HCPCS codes. Table 3 lists the deleted local codes, the replacement codes, and a description for clarification, effective with claims for dates of service on or after January 1, 2002.

Table 3 – Replacement Codes for Prenatal Care

Deleted Code	Replacement Code	Description
Z5900	H1000	Initial Assessment
Z5901	H1004	Reassessment
Z5902	99502	Postpartum Assessment/Outcome

Note: The code originally listed in BT200207 *for postpartum assessment/outcome is incorrectly listed as Z5092. The correct code is* Z5902.

Claims billed with procedure code *Z5900 – Initial Assessment, Z5901 – Reassessment,* and *Z5902 – Postpartum Assessment/Outcome* on or after December 31, 2001, will deny in Indiana*AIM* with an invalid procedure code for associated edits. Procedure codes used to bill prenatal care coordination mileage: *Z5490 – Two round trips per initial assessment, Z5590 – Two round trips per reassessment,*

and *Z5690 – One round trip per postpartum assessment*, will remain the same. Refer to the *Indiana Health Coverage Programs (IHCP) Provider Manual, Chapter 8, Section 3,* for prenatal care coordination mileage.

To All Rural Health Clinic and Federally Qualified Health Center Providers:

- The deletion of local code X3004, noted in bulletin *BT200207* affects Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). All providers using local code X3004 now have current rates loaded in Indiana*AIM* for the national HCPCS code T1015 effective for dates of service (DOS) January 1, 2002, and after.

  Claims paid for services provided after January 1, 2002, do not need to be resubmitted, if the rate is current. Claims with local code X3004 will not convert to HCPCS code T1015. Claims received after April 1, 2002, for DOS beginning January 1, 2002, deny if billed using local code X3004. If the encounter rate changes, claims with DOS prior to January 1, 2002, must be resubmitted or adjusted using local code X3004; however, claims for DOS after January 1, 2002, require the use of HCPCS code T1015.

  FQHCs currently using both local code X3004 and Current Procedural Technology (CPT) or HCPCS codes, assigned an interim rate by Myers and Stauffer, must convert their systems for the change to HCPCS code T1015. **RHCs** providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services currently using the local code X3004 must use HCPCS code T1015 for claims with DOS after January 1, 2002, submitted after April 1, 2002.

  The new *EPSDT Healthwatch Provider* manual is now available for download on the www.indianamedicaid.com Web site.

To All Nursing Facilities and Hospice Providers:

- The Marion County Superior Court ruled against the Office of Medicaid Policy and Planning (OMPP) in a lawsuit filed by Amhealth challenging the OMPP for imposing emergency rules as of October 1, 2001. The Court's ruling prevents the OMPP from carrying out these rules as of October 1, 2001. These rules change the case mix reimbursement methodology, reimbursement policy for bed hold days for nursing facilities, and hospice program members residing in nursing facilities, and crossover claims payment policies. However, be advised that the OMPP intends to implement the rules as follows:
  - Bed hold changes are effective May 1, 2002
  - Medicare crossover changes are effective May 1, 2002
  - Case mix changes are effective July 1, 2002

  Note: The permanent rules were separately promulgated, and are unaffected by the Marion County Superior Court order.

  The OMPP is continuing to evaluate what actions must be taken to comply with the Court's decision. Decisions include, but are not limited to, systems changes as well as rate recalculations. The OMPP must ensure that compliance with the court order is done in an orderly and uniform fashion. Notification to providers with details about reprocessing claims as well as future billing instructions will be given as soon as all decisions are finalized. Additional information and detailed billing instructions will be published in a future provider bulletin.

  Direct questions about this information to EDS Customer Assistance at (317) 655-3240 in the Indianapolis area or 1-800-577-1278 outside the Indianapolis area.

To All Dental Providers:

- The *405 IAC 5-14-8 Extractions* states, "If multiple extractions are performed on the same date of service, the maximum allowable payment for additional teeth will be reduced by 10 percent of the maximum allowable for the first tooth." *CDT-3* guidelines state, "*D7120, each additional tooth*. To be reported for an additional extraction in the same quadrant at the same visit." The interpretation is that *D7110, single tooth,* can then be billed one time per each quadrant. Currently the fee for *D7110, single tooth* is $72.25 and the fee for *D7120, each additional tooth,* is $66.50. The fee for *D7120* should be $65.02. Effective March 25, 2002, the rate for *D7120* has changed to $65.02.

To All Prescribers and Pharmacy Providers:

Note: The following information is not directed to providers rendering services in the Risk-Based Managed Care (RBMC) delivery system.

- This notifies providers of a State-assigned MAC rate change to the IHCP Over-the-Counter (OTC) Drug Formulary for Glucose Gel. The rate change is effective June 1, 2002.

Generic Name	State MAC Rate
Glucose Gel (40 percent Dextrose)	$0.06719 per gm